Meeting of the
Pharmacy and Therapeutics Committee
March 23, 2005
Minutes

Members Present:
Mark Szalwinski, R.Ph., Vice Chair
Avtar Dhillon, M.D.
Mariann Johnson, M.D.
Mark Oley, R.Ph.
Gill Abernathy, M.S., R.Ph.
Renita Warren, Pharm.D.
James Reinhard, M.D
Sue Cantrell, M.D

Absent:
Roy Beveridge, M.D
Arthur Garson, M.D.
Randy Axelrod, M.D., Chair
Christine Tully, M.D

A quorum was present

Guests:
Manikoth Kurup, MD, Member, Board of Medical Assistance Services
62 representatives from pharmaceutical companies, providers, advocates, associations, etc.

DMAS Staff:
Patrick Finnerty, Agency Director
Jane Woods, Secretary of Health and Human Resources
Cynthia Jones, Chief Deputy Director
Cheryl Roberts, Deputy Director of Programs and Operations
Bryan Tomlinson, Director Division of Health Care Services
Kim Piner, Counsel to the Board, Office of the Attorney General
Keith Hayashi, R.Ph, Pharmacist
Katina Goodwyn, Pharmacy Contract Manager

First Health Staff:
David Adams, Pharm.D, Rebate Support
Debbie Moody, R.Ph, Clinical Manager
Donna Johnson, R.Ph, Clinical Manager
Doug Brown, R.Ph, Rebate Support
Justin Lester, Pharm.D, M.B.A Rebate Support

OPENING OF MEETING BY MR. SZALWINSKI

Mr. Szalwinski, Committee Vice Chair, announced that Dr. Randy Axelrod, Committee Chair, was not able to be present and participate. He stated that the meeting will continue with a large agenda of issues to be addressed.

WELCOME AND INTRODUCTIONS FROM PATRICK FINNERTY, DMAS DIRECTOR

Mr. Finnerty thanked the Committee and the full audience for their attendance at the meeting. He stated that there were several issues for discussion at the meeting. The meeting would include a review of some new drugs in the phase one drug classes that have been in place for some time. The annual review for the PDL phase two and three drugs would also be conducted. Those were the main items on the agenda.

COMMENTS FROM THE SECRETARY OF HEALTH AND HUMAN RESOURCES

Secretary Woods thanked the Committee for their expertise, professionalism and their wisdom in the way that they have approached the process. She noted that the PDL has worked well for the people that we serve in the Commonwealth, those whose insurance is with Medicaid. Secretary Woods said that she wanted to give enormous thanks to everyone involved.

ACCEPTANCE OF MINUTES FROM December 8th, 2004 MEETING

Mr. Szalwinski asked if there were any corrections, additions, or deletions to the minutes from the December 8th meeting. None were noted and upon request of the Vice Chairman, the Committee voted on a motion and a second to approve the minutes of the December 8th meeting as written. The Committee voted to approve the minutes as drafted. Dr. Cantrell abstained as she was not present at the December 8th meeting.

OPEN ISSUES REVIEWED BY PATRICK FINNERTY, DMAS DIRECTOR

Mr. Finnerty reviewed the four budget amendments included in the General Assembly Conference Committee report that were passed during the recently concluded session, which directly affect the PDL program and P&T Committee. The General Assembly has recommended the amendments to the Governor for his review and on April 6th the Governor will recommend any changes to the budget during the reconvened session. The Department does not anticipate changes to the amendments as passed by the General Assembly. A listing of these amendments was available to the Committee in their meeting materials. The amendments are as follows:

The first amendment exempts antidepressant and antianxiety medications used for the treatment of mental illness from the Medicaid PDL program. Mr. Finnerty stated that the Committee previously reviewed these classes, made the recommendation that the classes be PDL eligible, and developed a recommended listing of preferred/ non-preferred drugs in these classes. In the previous Appropriations Act (2004 budget), the direction from the General Assembly was that if the P&T Committee was not going to specifically exclude the classes, they could not be implemented on the PDL until July 1, 2005. This was required so that the General Assembly could receive the P&T Committee's recommendations related to these classes and review DMAS' plan for implementation. DMAS completed reports to the General Assembly regarding the P&T Committee's recommendation and other information on implementation in October and December 2004, as required by the 2004 budget language. During the course of the 2005 General Assembly session they decided to exempt these drug classes from the PDL. DMAS will not implement these drug classes as required by the 2005 Act. The previous decisions and recommendations of the P&T Committee will not be rescinded; however, they will not be implemented. Letters will be sent to all affected manufacturers who submitted rebate contracts to DMAS.

(**Language (**Item 326 #4c): "7. The Department of Medical Assistance Services shall exempt antidepressant and antianxiety medications used for the treatment of mental illness from the Medicaid Preferred Drug List program.")

The second budget amendment in the Conference Committee Report further defines the composition of the P&T Committee. This amendment clarifies the composition of the Medicaid P&T Committee to ensure that at least one-half of the Committee is composed of professionals who provide services to Medicaid recipients. The current composition of the P&T Committee meets the standard of the amendment and no changes are required. Mr. Finnerty stated that the purpose of this amendment was to ensure that there is a close connection between the Committee and the community it serves.

(**Language** (Item 326 #8): "and the Department shall ensure that at least one-half of the physicians and pharmacists are either direct providers or are employed with organizations that serve recipients for all segments of the Medicaid population.")

The third amendment requires the Medicaid P&T Committee to schedule meetings quarterly and consider newly approved drugs for inclusion on the Preferred Drug List. In adherence with this legislation, a meeting has been scheduled for June 8th at which the Committee will discuss new drugs in the current PDL eligible drug classes.

(**Language** (Item 326 #2c): "3. The Pharmacy and Therapeutics Committee shall schedule meetings at least quarterly and meet at other times at the discretion of the Chairperson and members. At the meetings, the Pharmacy and Therapeutics Committee shall review any drug in a class subject to the Preferred Drug List that is newly approved by the Federal Food and Drug Administration, provided there is at least thirty (30) days notice of such approval prior to the date of the quarterly meeting.")

The last amendment requires the Department to report on the Preferred Drug List program annually and specifies data to be included in the report. Mr. Finnerty noted that the Department was already in the

practice of reporting to the General Assembly on the progress of the PDL. Even before the PDL was fully implemented, reports were developed and submitted to the General Assembly; some of these reports were required and others were non-required status updates. This will not be a change but a continuation of current practice.

(**Language** (Item 326 #3c): "8. The Department shall provide to the Governor; the House Committees on Appropriations, and Health, Welfare and Institutions; the Senate Committees on Finance, and Education and Health; and the Joint Commission on Health Care a report on the Preferred Drug List (PDL) Program no later than November 1 of each year. The report shall include the direct savings attributed to the PDL for the prior fiscal year, an estimated savings of the program for the next fiscal year, and the cost to administer the PDL. The report shall also include an analysis of the impact of the program on patient health including, but not limited to, hospitalizations and emergency outpatient visits.")

Mr. Finnerty noted in closing that the Department may ask the P&T Committee to consider new drug classes for PDL eligibility at its June meeting. They will notify the Committee of any new drug classes under consideration.

Mr. Finnerty stated that the program was running smoothly with very few complaints and a high compliance rate among prescribers and pharmacists. The success of the program is in large part due the efforts of the P&T Committee.

COMMENTS FROM MARK SZALWINSKI, COMMITTEE VICE CHAIR

Mr. Szalwinski thanked everyone for their attendance. He echoed Mr.Finnerty's earlier comments that because of the thoughtfulness and consideration of the members of the Committee, the PDL is a program that is serving the citizens of the Commonwealth very well.

DRUG CLASS REVIEW AND DISCUSSION

Mr. Szalwinski stated that presentations would be accepted for the specific drug classes listed on the agenda. He had a listing of all confirmed speakers who submitted requests to present as well as clinical references to peer reviewed studies completed since the last review of these classes (July 2004-present). He noted that on March 18th, all previously confirmed speakers were asked to re-submit requests with appropriate clinical references. Only speakers who were provided a second confirmation number in advance of this meeting would be able to present.

Mr. Szalwinski reiterated that all presentations must be clinical in nature and based on scientific material. No anecdotal accounts are to be given unless requested by the Committee. Presenters were told they had 3 minutes to present. A time clock was available to ensure that presentations were limited to this timeframe. Mr. Szalwinski recognized the importance of this clinical information to the decision making of the Committee and noted his appreciation for their time.

Mr. Szalwinski, later in the meeting, asked that each speaker make a declaration of conflict of interest in regards to the pharmaceutical industry, at the beginning of their comments.

NEW DRUGS IN PHASE I CLASSES

Mark Oley was asked to review the new drugs in Phase I classes.

Mr. Oley noted that this review was in accordance with the new General Assembly amendment reviewed by Mr. Finnerty and current P&T Committee policies. The new drugs in Phase I classes since the annual review of these classes were: Clarinex® Syrup, Clarinex® Redi-tab, Metoprolol HCT, Quinapril, and Somnote®. Of the listed products, Clarinex® is the only drug with two new formulations, two new generics available, and one new brand (created from an old drug) that have been released. With all new drugs except Somnote®, a clinical equivalent is currently established as preferred or non-preferred on the

PDL, based on previous P&T Committee review. Only drug pricing will need to be reviewed by the P&T Committee in the closed session related to these new drugs.

Dr. Gokul Gopalan, Medical Science Director - Schering-Plough, discussed Antihistamines/ 2nd Generation (*Clarinex® Syrup and RediTab*)

Dr. Gokul discussed Clarinex®. He noted that it is a very potent long acting non-sedating 2nd generation antihistamine. Its active drug is desloratadine. The difference between Claritin® and Clarinex® is the half life and the molecule size. Reditabs are orally disintegrating on the tongue, within seconds with or without water. The PK studies show that the Reditabs and syrup are bioequivalent to Clarinex® tablet and are used for the same indications. The syrup is the only non-sedating antihistamine indicated for various age groups for different indications.

ANNUAL REVIEW OF THE PDL PHASE II CLASSES

Joe Ogden, Regional Medical Liaison, Sanofi-Aventis discussed Oral Hypoglycemics/ 2nd Generation Sulfonylureas (Amaryl®)

Mr. Ogden reviewed two recently published articles and a study that is to be released this spring. Key points discussed by Mr. Ogden are the differences between sulfonylureas. He noted these differences as related to safety which are a lower incidence of severe hypoglycemia, dual route of excretion, safety in patients with renal and liver disease. Mr. Ogden cited that a pediatric type 2 study has been completed and is being filed in April 2005 for an indication in pediatric type-2 diabetes. A second difference that he discussed in sulfonylureas was in efficacy. Amaryl® improves 1st and 2nd phase insulin release which improves fasting plasma glucose (FPG) and preprandial plasma glucose (PPG). He reported that a 2% mean reduction in HbgA1c has been seen, and a 28% reduction in fasting glucose during Amaryl® trials. Lastly, cost is a difference between sulfonylureas. Scored tablets are easy to titrate allowing for 16 possible dosing options with less waste. There is a lower incidence of hypoglycemia; furthermore, Amaryl® is indicated for combination therapy with metformin and insulin. It is expected to have an indication from the FDA for type 2 diabetes in children this spring.

Charlie Kelly PharmD, CDE, Regional Scientific Manager from Takeda Pharmaceuticals discussed Oral Hypoglycemics/ Thiazolidineiones (*Actos®*)

Mr. Kelly discussed recent studies evaluating the oral hypoglycemic class thiazolidinediones (TZDs), in particular Actos®. He noted the class effect advantages of the TZD class. The TZD class has a positive effect on the two core defects of type-2 diabetes, which are insulin resistance and beta cell dysfunction. He had three main points from the information reviewed. First, Actos® has a favorable lipid effect; Actos® is the only TZD with this positive lipid affect as compared to Avandia® which does not. Second, Actos® is dosed once a day, which is a benefit for improved compliance in diabetic patients. Third, there are no clinically significant drug interactions with Actos® and other commonly prescribed medications.

Kerry Cunningham, Regional Medical Scientist, GlaxoSmithKline discussed Oral Hypoglycemics/ Thiazolidineiones (*Avandia®*)

Ms. Cunningham noted that Avandia® has been on the market for over five years and that it is a safe and effective oral treatment for type-2 Diabetes Mellitus (DM). It has been shown to increase beta cell pancreatic function. It is the only TZD indicated for triple therapy with metformin and a sulfonylurea. Ms. Cunningham reviewed a recent study, in which the addition of Avandia® to patients on maximum doses of a sulfonylurea and metformin resulted in over 65% of these patients achieving HbgA1c of less than 7.5% in 4 months. Also noted in this study were positive effects on lipid and inflammatory markers. Beneficial changes in the lipid profile have been shown with both of the TZDs, Avandia® and Actos®. Ms. Cunningham concluded by reviewing a study that evaluated restenosis of stints in diabetic patients. There was a high rate of restenosis of stints in the placebo group and a statistically significant lower rate of restenosis in the group on Avandia®.

Joe Aloi, MD, Endocrinologist practicing in Orange, Virginia who discussed- Oral Hypoglycemics/ Thiazolidineiones.

Dr. Aloi came to speak as a practicing physician to underscore the problem with managing type 2 diabetics. He noted that it is a really difficult to treat type-2 diabetes in the Medicaid population. He relayed the importance of the thiazolidinediones class of drugs and that the medical community is just beginning to know how important this group of drugs is with their unique ability to alter cardiovascular outcomes in diabetic patients.

Mark Oley asked if Dr. Aloi saw an advantage of one Thiazolidineione over the other as far as cardiovascular outcomes. Dr. Aloi replied that they both have unique qualities. The head to head trial that shows Actos® has a better effect on lipid profiles than the restenosis of stints study by Avandia® that has an advantage for the cardiovascular outcomes.

Melinda Mitton, Regional Medical Scientist, GlaxoSmithKline, discussed serotonin receptor agonists/ Triptans (*Imitrex*®)

Ms. Mitton reviewed the reformulation of Imitrex®. *RT Technology* is an innovative tablet formulation which is designed to enhance the dispersion and dissolution of oral tablets in the stomach, even in the presence of gastric stasis. After being swallowed whole, *RT Technology* allows the Imitrex® tablet to quickly disintegrate and rapidly release into the bloodstream. To ensure proper delivery of the intended dose, tablets should not be cut. Nearly 100% of Imitrex® is dispersed within 2 minutes. Peak plasma levels are reached 10 to 15 minutes earlier than conventional tablets. Ms Mitton reviewed clinical trials that evaluated the onset of pain relief within 20 minutes of onset of headache with Imitrex® 100 mg and 30 minutes with Imitrex® 50 mg. This is an improvement from conventional tablets. According to Ms. Mitton, no oral triptans have been proven to be superior to the conventional Imitrex® tablets in adequately designed clinical trials. Because of the well documented efficacy, tolerability, safety and multiple formulations that Imitrex® has available, Ms. Mitton believes Imitrex® to be a good choice for the PDL.

Dr. Neil Pugach a Neurologist from Neurological Associates of Hampton Roads, PLLC discussed serotonin receptor agonists/ Triptans

Dr. Pugach had two main points. The first was that with triptans "one size does not fit all". The second point was that if he could only have one product in addition to Imitrex®, he would want it to be Relpax®. He reviewed studies that, in his opinion, warranted using Relpax as a rescue drug for migraine pain not relieved by other triptans, or in the event of failure of Imitrex®.

Gill Abernathy asked with the non-responders in the study, if the rescue dose of Relpax® was given verses a subsequent dose of Imitrex® or a dose of Relpax® with no additional dose of Imitrex®. Dr. Pugach replied that in one study, the patients had documented in their charts that they had a history of 6 months as non-responders to Imitrex® and in the study they were not given Imitrex®.

Mark Szalwinski stated that he neglected to ask earlier but generally individual practitioners are asked to state, prior to their comments, whether they have any conflicts of interest, honorarium, etc. based on their speaking engagement. Mr. Szalwinski apologized for this oversight. Dr. Pugach stated that he had no honorarium for today's presentation; however, he has given "talks" for every one of the triptans except for Malxalt® because they essentially stopped their speaker training program.

Dr. George Karkanias, Regional Medical Research Specialist for Pfizer, discussed serotonin receptor agonists/ Triptans/ Relpax®

Dr. George Karkanias referred to Relpax® as the product of rational drug design. He noted that the chemist at Pfizer studied triptans chemical structure for over ten years. He claimed that Relpax® is the next generation in triptans with 10 times the binding affinity at receptor site, faster Tmax than other triptans. He

stated that the Furrier med analysis reviewed compared all 7 triptans, compared to data on the market, and Relpax® is the best choice. He stated that there is a documented lower reoccurrence rate with Relpax® compared to other triptans and that only Relpax® showed a sustained improvement over all other in various studies.

Steven Soper, Medical Communications, Professional & Scientific Relations, Osteoporosis Specialist from Procter & Gamble discussed Osteoporosis Agents/Bisphosphonates *(Actonel®)*

Mr. Soper reviewed recent trials and noted that Actonel® provides rapid fracture reduction across the skeleton and is the only agent prospectively proven to rapidly reduce fractures across the skeleton at 1 year. Actonel® demonstrated an 86 % risk reduction over 1 year in the prevention of hip fractures. Actonel® reduced the risk of clinical vertebral fractures at 1 year by 69 % and reduced the incidence of nonvertebral fractures at 1 year by 74 % vs. control. Mr. Soper claimed that Actonel® is the only agent to prove fracture reductions as early as 6 months at the spine and at composite nonvertebral sites. Mr. Soper reported that recent studies show that rapid fracture protection is important because after a vertebral fracture 26 % of women fractured again within 1 year. Actonel's® rapid fracture protection and GI tolerability data have recently been supported with results from real world database research which showed superior 1 year nonvertebral fracture reduction and superior GI tolerability to Fosamax®. Mr. Soper claims that Actonel ®is the preferred Bisphosphonate agent at the three largest pharmacy consulting companies, which account for >80% of nursing home beds. Mr. Soper noted that it is important to put the data from the recently completed FACT study into perspective. No comparative fracture reduction conclusions between Actonel ®and Fosamax® can be reached despite greater gains in bone mineral density (BMD) and greater reductions in bone turnover markers seen with Fosamax in this study. There were actually a greater number of patients in the FACT trial who fractured on Fosamax® (26 fractures) vs. on Actonel ® (20 fractures). This study had many non-responders (those who lost BMD) on Actonel® vs. Fosamax®.

Mr. Szalwinski reminded the group that only clinical data were to be reviewed no anecdotal data should be reviewed. Mr. Szalwinski asked the presenters only include new information that the Committee needs to make PDL decisions.

Allan I. Goldberg, M.D., Executive Medical Director, Mid-Atlantic Region from Merck & Company discussed Osteoporosis Agents/Bisphosphonates (Fosamax®)

Dr. Goldberg reviewed the new FACT trial data. The recently published "FACT" trial (Fosamax® Actonel® Comparison Trial), was a double-blind, head-to-head comparison of oral alendronate, 70 mg weekly, with oral risedronate, 35 mg weekly in 1053 postmenopausal women over a period of 12 months. The primary outcome measure was the change in hip trochanter bone mineral density (BMD) at 12 months. The study also evaluated the change in total hip BMD, femoral neck BMD, and lumbar spine BMD, as well as the change in levels of bone turnover markers. At all time points, there was a significantly higher increase in BMD in the alendronate group compared with the risedronate group. In addition with the bone turnover markers, there was a significantly higher reduction by month 12 in the alendronate group compared with the risedronate group. These data indicate that alendronate, 70 mg once per week, seemed to reduce bone remodeling more than risedronate – resulting in larger increases in BMD. This study was not powered or designed to determine reduction in fractures. To be powered to show observes fracture reduction the in excess of 50,000 patients, so 2,000 patients were hardly enough patients to draw a conclusion on fractures. Currently BMD (most commonly) and markers for bone turnover (such as NTx, BSAP, and CTx) is the surrogate markers used to initiate and monitor therapy. The study did show statistically significant improvement in BMD with Fosamax®.

ANNUAL REVIEW OF THE PDL PHASE III CLASSES

Elizabeth Kim, MD, US Medical Director, Ophthalmology from Pfizer discussed Glaucoma/ Prostaglandin (PG) Analogues (Xalatan®)

Dr. Elizabeth Kim presented key differentiating aspects of Xalatan® therapy. The two major points reviewed were the claim that Xalatan has superior tolerability among prostaglandins and Xalatan® has the best persistency among glaucoma therapies. The efficacy of Xalatan in lowering intraocular pressure (IOP) has been proven in many clinical trials and similar efficacy is seen in the class of prostaglandin analogs. Xalatan has consistently demonstrated improved tolerability in head to head clinical studies. Xalatan has less ocular hyperemia than the other 2 PGs. In a study conducted by Parrish, at week 12 the 16% rate of ocular hyperemia for Xalatan was significantly lower than reported rates for the other two agents: 34.8% for Lumigan® ($P<0.01$ vs. latanoprost) and 27.3% for Travatan ($P=0.027$ vs. latanoprost). The analysis of hyperemia severity parallels the reported frequency of hyperemia, with Lumigan showing the most severe mean hyperemia followed by Travatan®. Xalatan® has the mildest hyperemia. Mean severity of ocular hyperemia tends to remain constant from week 2 onward. Persistency on therapy is a crucial behavior for full benefits of glaucoma treatment. A substantial number of glaucoma patients discontinue treatment within the first 6 months and this number increases over time. Variability in persistency is most closely linked with differences in effectiveness and tolerability of medications.In conclusion, Dr. Kim stated Xalatan is the only PG with a first-line indication approved by the FDA. Moreover, the FDA granted 3-year exclusivity to Pfizer for the first-line indication based on a 5-year safety study. Xalatan has remained the most highly prescribed agent by ophthalmologists because the medication offers long term IOP control, tolerability and convenience, which all positively impact patient persistency with the end result to optimize treatment success and delay or prevent the progression of glaucoma to blindness.

William Waschler M.D., Petersburg Eye Center discussed Glaucoma/Prostaglandin Analogues

Dr. Waschler stated he has no affiliation with drug manufacturers**.** He reviewed the prostaglandin analogues for use in treatment of open angle glaucoma. He relayed that the most effective and first choice agent used most often in treatment is a prostaglandin analogue. Dr. Waschler stated that it is crucial to understand the differences in both efficacy and side effects for each individual PG agent. The only head to head to head study comparing these criteria was published in December 2003 in the American Journal of Ophthalmology. Dr Waschler is part of a large group practice in Petersburg and Colonial Heights. He sees many economically challenged Medicaid and Medicare patients. He stressed the importance to be able to make therapeutic choices in the best interest of these patients. Not all prostaglandins work for the long term with the same side effects. He stated that it is important to be able to switch agents, if necessary, and choose the one that the patient's best tolerate over the long term. Compliance has always been a problem with chronic disease states. He presented a Comparison of Latanoprost, Bimatoprost and Travoprost in patients with elevated intraocular pressure: A 12 week, randomized, masked-evaluator multicenter study (Am J Ophthalmol. 2003;135:688-703 Clinical Experience regarding measurement of IOP; Compliance issues facing patients on Glaucoma Therapy Side effects associated with various PG's). He stressed the concern with the side effect of hyperemia.

Gill Abernathy asked, if a patient could be identified in advance that they will have this side effect?

Dr. Waschler responded no, you have to try the drug and if the patient has the side effect then you change drugs.

Shonda Foster, PharmD, MS, Outcomes Liaison Consultant from Eli Lilly and Company discussed CNS Stimulants/ADHD Medications (Strattera® - atomoxetine)

Dr. Foster noted that according to recent studies cited, Strattera® has efficacy superior to placebo in treating the core symptoms of attention-deficit hyperactivity disorder (ADHD) in children, adolescents, and adults. Additionally, Strattera® is the first ADHD therapy specifically indicated for adults and clinically proven to treat ADHD successfully in this population. Dr. Foster noted that the benefits of

Strattera® have been shown to last throughout the day and evening both at school and home with a single dose in the morning. A variety of assessments have been used in three trials to demonstrate Strattera's® efficacy in multiple settings. Taken together, findings from these studies prove that Strattera offers all-day relief at home and school. Strattera® is not contraindicated in patients with tics or anxiety, unlike stimulants, which are contraindicated in these conditions. Strattera does not provoke the new development of tics in patients with ADHD and actually improved tics in patients with comorbid Tourette's Disorder. Lack of insomnia associated with Strattera® use in children is particularly noteworthy, given insomnia is commonly associated with stimulant therapy. In a double-blind study assessing time to onset of sleep, the reported mean increase in time to onset of persistent sleep when patients took Strattera was significantly less than the reported mean increase when they took methylphenidate. Strattera® has a very low abuse or diversion potential. Dr. Foster noted that Strattera® is a first line treatment for ADHD recommended by the most recent American Academy of Child and Adolescent Psychiatry (AACAP) guidelines. In conclusion Strattera® is a safe and tolerable medication that provides continuous relief of systems and prevents relapse in patients maintained on therapy for up to a year. It is safe and effective in patients with co-morbidity such oppositional defiant disorder (ODD), ticks and anxiety.

Dr. Dhillon asked about liver safety. Dr. Foster reviewed the current liver warning that there is a warning to monitor liver functions with Strattera®. Dr Foster added that to date only two cases out of 2 million patients have been identified with liver damage.

Ronald B. David MD, Child Neurologist in Richmond, speaking for McNeil, discussed CNS Stimulants/ADHD Medications (*Concerta*®)

Dr. David is on the speakers Bureau for Novartis, Lilly and Shive. He believes that Concerta® has certain advantages over other agents and requested that Concerta® is kept on the Virginia PDL. Dr. David noted that Concerta® offers better over all compliance because it is long acting agent. He stated that there is less likelihood of injury or accidents with this agent. Over all health care cost are reduced by using an agent like this as opposed to multiple dosing. He noted that it has a low potential for abuse as, it cannot be snorted. It has an s ending PK curve that provides adequate 9 to 12 hours dosing. He concluded by reviewing a study by Cox from UVA reported that when driving was measured with a driving simulator as well as on an open road testing, driving was improved by a virtue of improved vigilance or on task behavior through the use of Concerta®. This group of individuals tested, represent a group who is at high risk of accidents, but because of improved focus, driving scores improved. Individuals who are 15 to 20 years of age are the group who are at high risk for doing harm to themselves as well as other individuals.

Dennis Pontani, MS, Ph.D., Director, Regional Medical Director, from Pfizer, Inc discussed Antibiotics/Macrolides (Azithromycin)

Dr Pontani noted that many trials have been completed over past few years involving azithromycin for treating a wide variety of respiratory track infections. In these trials they compare azithromycin to macrolides as well as to beta lactams and the new generation fluoroquinolones. All of these results show that this product is highly efficacious antibiotic in the treatment of community acquired respiratory tract infections; it is also safe and well tolerated with a very low incident of drug interactions. He reviewed new guidelines published by the American Thoracic Society, Infectious Disease Society of America and the Centers for Disease Control. The guidelines address the use of dual therapy of a cephalosporin plus a macrolides as first line therapy for Community-Acquired Pneumonia (CAP) in hospital patients. They compared the dual therapy to monotherapy and concluded that the dual therapy has a reduced length of stay and decrease mortality.

Steven P. Smith, Pharm.D., MBA, BCPS, BCOP, Senior Manager, Regional Scientific Services, from Janssen Ortho-McNeil Scientific Affairs discussed Quinolones/ 3rd Generation (*Levaquin*®)

Dr. Smith noted that Levaquin® now has 11 FDA-approved indications. Most recently, inhalational anthrax and multi-drug resistant pneumococcal pneumonia were added as indications. A new bubble gum mint flavored oral solution was approved in 2004. Dr. Smith noted that Levaquin® has an outstanding efficacy

in the treatment of respiratory tract, skin/skin structure infections and urinary tract infections. Two recent papers built upon the previously approved 5-day indication for community-acquired pneumonia (CAP). File et al in Current Medical Research and Opinion (2004; 20:1473-81) demonstrated faster resolution of fever with 750mg of Levaquin® given for 5 days compared with 500mg for 10 days. Short course therapy may improve patient compliance (10 days v 5 days of therapy) and decrease exposure to collateral bacteria from 5 grams to 3.75 grams. Dunbar et al in Current Medical Research and Opinion (2004; 20:555-63) demonstrated the efficacy of Levaquin® 750 mg for 5 days against atypical pathogens that cause CAP. Recently published treatment guidelines for nosocomial pneumonia from the American Thoracic Society and the Infectious Diseases Society of America (Am J Respir Crit Care Med 2005; 171:388-416) endorsed Levaquin® as one reliable choice in combination with a broad spectrum cephalosporin.
Dr. Smith noted that there is a proven safety record with Levaquin® it has a lower side effect profile compared to other fluoroquinolones.

Dr. Tim Myers, Medical Science Specialist from Schering-Plough discussed Antibiotic/ Quinolones 2nd & 3rd Generation (*Avelox*® *and CiproXR*®)
Dr. Myers discussed that his studies show that Avelox® was associated with significantly faster recovery than levofloxacin at days 3-5, Avelox® has fewer clinical failures and a reduced need for additional or alternative antimicrobial therapy. Dr. Myers discussed that the safety profile of Avelox® was similar to levofloxacin. He reported that the New CAPRIE study compared Avelox® vs. levofloxacin in CAP. Safety has been an end point in some of the studies. Avelox® is a good quinolone to use in respiratory infections because it has more gram positive activity. Dr. Myers discussed that as we shorten the burst of antibiotic doses, we increase the potential harm that a missed dose can cause with these products.

Thomas J. Ferro, M.D., Professor of Internal Medicine at MCV/VCU Health System, discussed antibiotics
Dr. Ferro reviewed the following study "Patient adherence to prescribed antimicrobial drug dosing regimens" (Vrijens B, Urquhart J., J Antimicrob Chemother. 2005 Mar16; [Epub ahead of print]).
This paper reviewed antimicrobial dosing regimes and compliance. Dr. Ferro discussed the noted paper that reviewed pharmionics. Pharmionics is a way to monitor and access compliance with antibiotic regimens. Two points that Dr. Ferro stressed were that noncompliance is a much bigger issue than ever thought. It is more than twice as bad as ever imagined. The second point is that viral titer does increase with noncompliance and increased resistance.

David Williamson, PhD, Senior Manager of Regional Scientific Service, Janssen Ortho McNeil Pharmaceuticals discussed Long Acting Narcotics (transdermal fentanyl)
Dr. Williamson reviewed the indications for Duragesics®. He also reviewed new progress in understanding Duragesics'® potential role in the treatment of chronic low back pain (CLBP). In a 13-month treatment study, Duragesic® provided comparable pain relief with significantly less constipation than sustained-release oral morphine. A 9-week observational study performed at 17 US pain centers demonstrated that significantly fewer CLBP patients report limitations in physical and social activities such as walking, or carrying groceries. Even patients reporting "small" relief in pain severity report substantial increases in Health- Related Quality of Life and clinically meaningful reductions in disability.
There is a low incidence of abuse with Duragesics®.

Matthew Gainey, Pharm.D., Medical Liaison from Purdue Pharma L.P. discussed Long Acting Narcotics
Dr. Gainey discussed Purdue's new schedule II opioid analgesic, Palladone™ Capsules (Hydromorphone hydrochloride extended-release). Currently, the Virginia PDL has four long acting opioids, three of which are morphine. Dr. Gainey discussed Palladone™ and encouraged the Committee to refer to the boxed warning and professional prescribing information provided for complete details regarding the indications, warnings, contraindications, and dosage and administration recommendations. Palladone™ represents the only FDA approved extended-release formulation of hydromorphone, which allows it to be administered

every 24 hours. Palladone™ is indicated for the management of persistent, moderate to severe pain in patients requiring continuous, around-the clock opioid analgesia with a high potency opioid for an extended period of time, generally weeks to months or longer. Palladone™ should only be used in patients who are already receiving opioid therapy, have demonstrated opioid tolerance, and require a minimum total daily dose of opiate medication equivalent to 12 mg of oral hydromorphone. Appropriate patients for treatment with Palladone™ include patients who require high doses of potent opioids on an around-the-clock basis to improve pain control, and patients who have difficulty attaining adequate analgesia with immediate release opioid formulations. Palladone™ Capsules are NOT intended to be used as the first opioid product prescribed for a patient, or in patients who require opioid analgesia for a short period of time. Palladone™ Capsules are contraindicated for use on an as needed basis, i.e., PRN. Palladone™ capsules are to be swallowed WHOLE and are not to be broken, chewed, opened, dissolved or crushed. Consuming alcohol while taking Palladone™ Capsules or taking the tablet broken, chewed, dissolved, crushed Palladone™ capsules or its contents can lead to the rapid release and absorption of a potentially fatal dose of hydromorphone. Hydromorphone is a potent Schedule II opioid agonist. Schedule II opioid agonists have the highest risk of fatal overdoses due to respiratory depression, as well as the highest potential for abuse. Palladone can be abused in a manner similar to other opioid agonists, legal or illicit.

Dr. Mark Flanzenbaum; Emergency Room Physician, Bon Secours St. Mary's Hospital discussing Serotonin Receptor Agonists/ Triptans

Dr. Flanzenbaum discussed triptans and requested keeping Imitrex® on the PDL. He cited that the reformulation of the tablets allows these tablets to be easily and quickly dissolved even with gastric status. This allows for increased onset of relief. A positive feature of Imitrex is the flexibility of all of the different formulations. Different triptans may be mixed. Dr. Franzenbaum stated that it is very safe to go from one form of Imitrex® to another form as a rescue dose.

COMMENTS FROM OFFICE OF THE ATTORNEY GENERAL

Ms. Kim Piner from the Attorney General's office stated that under the Virginia Freedom of Information Act (FOIA), specifically Virginia Code section 2.2-3711, a public body such as the P&T Committee, may go into a closed session for any of the 33 reasons listed in that statute. The discussion of manufacturer and wholesaler prices is not one of the 33 reasons listed.

She stated the Attorney General strongly supports the principles of open government embodied by the FOIA and believes in the opportunity of the Commonwealth's citizens to witness the operation of government to the fullest extent.

Federal Law 42 U.S.C. 1396r-8(b)(3)(D) requires such pricing information to be kept confidential. On this point federal law supersedes the Virginia FOIA. Since the P&T Committee must discuss this pricing information as part of its duties, pursuant to federal law a confidential meeting must occur for the consideration of this pricing information she cautioned only this confidential information should be discussed.

Mark Oley made a motion for the P&T Committee to resume the meeting in another room to discuss this confidential information regarding prices charged by the manufacturers and wholesalers of the drug classes discussed today at this P&T Committee meeting. This confidential meeting is authorized by Federal Law at 42 U.S.C. § 1396r-8(b) (3) (D) that requires this information to be kept confidential.

This motion was seconded and unanimously approved by the Committee.

The meeting adjourned to an executive session.

P&T COMMITTEE DISCUSSION

The Committee returned to the public meeting, a motion was made to resume the meeting. The motion was seconded and unanimously approved by the Committee.

Mr. Szalwinski asked for a motion for the annual review for Phase II PDL and Phase III PDL Classes

Mark Oley motioned that based on the annual review for Phase II and Phase III PDL classes the following would remain unchanged in the next year:

Oral Hypoglycemics
Second Generation Sulfonylureas
Alpha Glucosidase Inhibitors
Biguanide Combinations
Biguanide Type
Meglitinides
Thiazolidinediones (TZD)
Leukotriene Modifiers
Serotonin Receptor Agonists
Onychomycosis Antifungals
Carbonic Anhydrase Inhibitors
Alpha 2 Adrenergics
Beta-blockers
Prostaglandin Inhibitors
Antihyperkinesis/CNS Stimulants
Macrolides
2nd Generation Cephalosporins
3rd Generation Cephalosporins
Long Acting Narcotics

All of these classes will remain PDL eligible with the same drugs designated as preferred and non-preferred:

This motion was seconded and unanimously approved by the Committee.

Mark Oley motioned to add Fosamax® and Fosamax® Solution as preferred in the Bisphosphonates for Osteoporosis class.

This motion was seconded and unanimously approved by the Committee.

Mark Oley motioned that in the Quinolones (2nd generation) class, Ciproflaxacin would be added as preferred, while Cipro and Cipro XR would be deleted and made non-preferred.

This motion was seconded and unanimously approved by the Committee.

Mark Oley opened discussion on moving Mobic® from the non-steroidal anti-inflammatory drug (NSAID) to the COX 2 inhibitors class.

Mr. Szalwinski opened for discussion the consideration of Mobic® as a COX-2 inhibitor given the current scenarios in the marketplace and the clinical information that is being provided in the market around COX-2s and Mobic®.

Mark Oley stated that given the current status of COX-2s and the way it {Mobic} is being marketed by the company as a COX-2 inhibitor, he suggested that the Committee consider putting Mobic in that class with a prior authorization requirement in place until the Committee has the next discussion of the COX-2 class.

Mr. Szalwinski called for further discussion by the Committee and there was none. Mr. Szalwinski clarified that the motion was for Mobic to be deleted from the current PDL (made non-preferred in the NSAIDs class). He also indicated that the Committee would consider reviewing Mobic with the COX-2 drugs in the fall and, if included, placed under the same criteria as are currently being used for COX-2 inhibitors.

This motion was seconded and unanimously approved by the Committee.

Mark Oley clarified that the non-steroidal anti-inflammatory drug (NSAID) class would remain the same with the exception of Mobic®.

Post meeting clarification:
Beginning in July 2005, Mobic will be a non- preferred non-steroidal anti-inflammatory drug (NSAID). When theCOX-2 inhibitors class is reevaluated in the fall, the P&T Committee will consider reviewing Mobic along with other drugs in this class. Celebrex, Bextra and Vioxx, are part of the Cox-2 inhibitors, a newer type of non-steroidal anti-inflammatory drug (NSAID). Mobic does have particular prostaglandin inhibitor properties that has caused it to be classified as a Cox-2 in some countries but is not considered part of that group in the United States, where it is only classified as part of the larger NSAID class. The manufacturer has not marketed Mobic as a COX-2 in the United States. Mobic does have a higher COX-2 specificity than other traditional NSAIDs and does fit clinically into the COX-2 class.

In addition, since the P&T committee meeting, DMAS learned that the Federal Drug Administration (FDA) requested that Pfizer voluntarily withdraw Bextra, a COX-2 drug, from the market. Pfizer agreed to suspend sales and marketing in the United States. Prior to this announcement, Bextra was a non-preferred drug in the Cox-2 drug class on the PDL and required prior authorization for coverage. Effective April 7th, prior authorizations will no longer be granted for Bextra and it will not be reimbursable. The preferred drug in this class is Celebrex, which will continue to be reimbursed without PDL prior authorization. The clinical edit is also still in place requiring patients under age 60 to try two Non-steroidal Anti-Inflammatory Drugs (NSAIDs) or have a designated, existing co-morbid condition before approval of a Cox II drug.

Mark Oley motioned to accept Metoprolol HCT (Beta Blocker), from the new drugs in PDL phase I classes, as a preferred drug for the PDL.

The rest of the new drugs in PDL Phase I classes that were reviewed will be non-preferred. These drugs include the following:
Clarinex® Syrup
Clarinex® Redi-tab
Quinapril
Somnote®

This motion was seconded and unanimously approved by the Committee.

Mr. Szalwinski asked if there were any other matters to come before the Committee. There were none. Mr. Szalwinski expressed his appreciation to the Committee for their time. The next meeting will be on June 8, 2005 in the morning.

Vice Chairman Mr. Szalwinski adjourned the meeting at 1:10 p.m.